Lavender Lodge Limited

Lavender Lodge Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Lavender Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The inspection took place on 17 and 18 January 2018. The first day of the inspection was unannounced.

At our last inspection we identified a regulatory breach which related to safe care and treatment. At this inspection we found the registered provider had not made sufficient improvements in this area and we found a further breach of regulation 17 good governance. Following our inspection the representative of the registered provider sent us an action plan which showed how some of our immediate concerns would be addressed.

The home provides personal care and accommodation for older people, people with dementia, and people with a physical disability.

A registered manager was in post. This is a condition of the registration of the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

People and their relatives told us they were safe living at this service. However, we found the registered provider had identified safeguarding concerns in February and August 2017 which they had not reported to the Care Quality Commission (CQC).

During our inspection, we found there were still concerns regarding people's safety. We found medicines were not managed safely as not all staff responsible for the administration of medicines had made sure that a person's medicine was not accessible to other people.

People's risk assessments provided staff with information on how to support people safely, though some assessments were not fully in place. Lessons to prevent incidents occurring had not comprehensively learnt from past events. People were not fully protected from the risks of infection.

Staff had been trained in safeguarding (protecting people from abuse) and, in the main understood their responsibilities in this area, though staff needed more training in which relevant outside agencies to contact.

People using the service and the relatives we spoke with, except one person, said they thought the home was safe.

Staff support through a programme of training, was not up to date. Most recruitment checks had been carried out safely to ensure staff were suitable to work with vulnerable adults.

Staff had been trained to ensure they had the skills and knowledge to meet people's needs, though they were unsure what this meant in practice. Staff understood their main responsibility under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) to allow, as much as possible, people to have an effective choice about how they lived their lives, although they were of all their responsibilities under this law.

People did not always have the opportunity to have sufficient quantities to eat and drink. Everyone told us they liked the food served. People's health care needs had been protected by referrals to health care professionals when necessary.

People told us they liked the staff and got on well with them. We saw many examples of staff working with people in a friendly and caring way, though one person reported there had been occasions where staff had not shown respect. People and their representatives were not always involved in making decisions about their care, treatment and support.

Care plans were individual to the people and covered their health and social care needs. Some activities had been organised to provide stimulation for people, though stimulation which suited people was not always available.

People and relatives, except two relatives, told us they were confident any concerns they expressed would be followed up.

People and relatives, except two relatives, and staff were satisfied with how the home was run by the registered manager.

Management had not carried out audits and checks to ensure the home was running properly to meet people's needs. Essential issues had not been comprehensively audited.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risk assessments to promote people's safety were not always in place. Lessons had not always been learned from past safety incidents. Medicine had not always been safely supplied to people. People had not been comprehensively protected from the risk of injury or the risk from infection. Staffing levels were sufficient to keep people safe. Staff recruitment checks were in place to protect people from unsuitable staff. People and relatives told us that people were safe living in the service. Staff knew how to report any suspected abuse to their management though staff had not been informed how to refer to external agencies if necessary.

Is the service effective?

Requires Improvement

The service was not always effective.

People told us that they received effective staff support to meet their needs. Staff were trained and supported to meet people's needs, though some training on people's health conditions had not been provided. People's consent to care and treatment was not always sought in line with legislation and guidance. People told us they liked the food served. There was positive working with and referral to health services.

Is the service caring?

Good

The service was caring.

People we spoke with, except one person, told us that staff were kind, friendly and caring and respected people's rights. Overall staff respected people's independence and dignity. People's religious and cultural issues have been met. People and their relatives had not been involved in setting up care plans that reflected people's needs.

Is the service responsive?

Requires Improvement

The service was not comprehensively responsive.

Care plans contained information for staff on how to respond to people's needs. Care had been provided to respond to people's needs. Activities based on people's preferences and choices were available to them, though this was a limited range. People told us that management listened to and acted on their comments and concerns. The complaints system did not evidence that complaints had been handled appropriately to meet concerns of complainants.

Is the service well-led?

Requires Improvement

The home was not comprehensively well led.

Essential systems had not been audited in order to ensure that people were always provided with a quality service. We had not always been informed, as legally required, of serious incidents affecting the service. No information was available which clarified governance duties and responsibilities for management and staff. People or their relatives had not been comprehensively consulted on the running of the service. Most people and their relatives told us that management listened to them and put things right. Staff told us the management team provided good support to them and had a clear vision of how friendly individual care was to be provided to meet people's needs.

Lavender Lodge Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Lavender Lodge provides personal and nursing care and accommodation for up to 44 people. On the day of the inspection the registered manager informed us that 42 people were living at the home.

The inspection was unannounced. The inspection team consisted of an inspector and an expert by experience and a specialist adviser. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert by experience had experience of people with mental health needs. A specialist adviser is a person who has expertise of the client group of the service. The specialist adviser was a qualified nurse who had expertise of nursing care.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was received in a timely way and was completed fully.

We reviewed the provider's statement of purpose; this is a document which includes a standard required set of information about a service. We also reviewed the notifications submitted to us; these are changes, events or incidents that providers must tell us about. We looked at information received from local authority commissioners. Commissioners are responsible for finding appropriate care and support services for people.

We used a variety of methods to inspect the service. We spoke with people using the service, their relatives and friends or other visitors, interviewed staff, tracked people's care, we observed how people were

supported during individual tasks and activities. We also spoke with five people living in the home, five relatives, the registered manager, two nurses and six care staff.

We looked at records relating to all aspects of the service including care, staffing and quality assurance. We also looked in detail at five people's care records.

Requires Improvement

Is the service safe?

Our findings

Systems were not comprehensively in place to keep people safe.

A risk assessment tool had been completed for a person at risk of falls, however there was no risk assessment in place to inform staff how to protect the person safety to prevent them from falling.

A risk assessment was in place for a person that was risk of developing pressure sores. The risk assessment said that staff needed to assist the person to change their position to prevent pressure sores developing, every 3 to 4 hours. However, in January 2018, over a three day period, records did not indicate that this was being carried out. The registered manager thought this care had been carried out but agreed that records did not provide assurance this support had been provided.

A person with diabetes had a form in place so that their blood sugar could be checked. However, there was no indication at what level staff needed to contact health professionals if the person's blood was outside the safe range. The registered manager said this would be followed up.

A nutritional assessment was in place for a person who had been assessed as at risk from a lack of nutrition. Although they had been referral to a specialist, and the specialist report stated what type of food and fluids were needed, this had not been incorporated into the person's care plan and risk assessment. This meant there was a risk that the person would not receive adequate food and fluids.

Another person at risk of malnutrition had no lunch. Staff said they had had a good breakfast and therefore they were not hungry. Food records for breakfast showed they only had less than half a slice of bread with baked beans and three spoonful's of cereal. This intake was not at a safe level to prevent malnutrition. The registered manager said this issue would be followed up with the GP.

There was no fluid target volume tool in use in care plans. This meant staff were unable to see the level of fluid needed for anyone to be safely prevented from the risk of dehydration.

A number of people had falls. Falls had been recorded in the care files, but none of the reports had any positive further action/investigation or reporting recorded. There was no audit of falls. This resulted s in trends not being identified and appropriately acted upon. For example, for those people who had multiple falls at particular locations, and at what times of the day or night. This would enable safe risk assessment review to indicate common risks requiring intervention. None of the people with a history of falls were referred either to the local falls prevention team or the person's GP.

One person had 10 falls recorded over the past 12 months but no evidence of any referral to any external agency. They had been admitted to hospital in February 2017 with a further admission to hospital in September 2017. However, no further action was recorded to minimise the falls risk.

There was no analysis in place to see if such incidents could have been prevented by, for example increased

staff monitoring or the use of relevant equipment. The information did not always include if falls had been witnessed and the location of where the person fell to allow proper analysis of falls. For example, an incident in December 2017 did not give any reasons why the incident occurred and whether anything else could have been done to prevent this in the future. This meant that information was not in place to ensure that lessons were learned and shared with staff to prevent reduce the potential for such incidents in the future.

Some staff had received fire evacuation training in June 2017. It was not clear all staff, including night staff, had received training and been involved in a fire drill in the past year. The registered manager said this would be followed up. A fire risk assessment was in place. However, this had not been reviewed since 2010. At this last review, there were 15 recommendations from the fire assessor to ensure fire standards were sufficient to protect peoples' safety. However, there was no evidence that any action had been taken. The registered manager said these issues would be followed up.

The premises did not always protect people safety. In one toilet, the linoleum had not been tacked down by the toilet frame. In a bathroom, the linoleum had not been levelled evenly to the floor. This meant a risk of people tripping due to the unevenness of the floor. There was no grab rail for people to hold onto in one toilet. This meant a risk of people falling when using the toilet. The registered manager said this would be installed.

Information about the prevention and control of infection in care homes was available. However, the home was not all clean and tidy. There was staining on a toilet bowl and brown marks on the floor by the sink in a toilet. In another toilet, there was stain marks on the toilet bowl and stains around the plughole on the wash basin. Grouting was cracked on wash hand basins in two toilets. There was an odour in one toilet. There was a strong smell of urine in many bed rooms. This predominantly came from soft furnishings which were difficult to clean. In one bathroom, a bin without a lid was full. These were infection control risks and demonstrated the lack of robust infection control audits.

We saw staff assisting a person to move from a sofa to a standing frame. Staff used a lot of pressure with their hands on the person's back to enable the person to stand up. However, this manoeuvre did not follow safe moving and handling principles. They had a risk of injuring the person and themselves. The registered manager said moving and handling practice would be reviewed to see whether the person was in need of equipment to safely move from one place to another.

Staff assisted people who used wheelchairs. However, with one person, there was only one footplate on the wheelchair. This meant the person had to put both feet on this footplate. For another person, there were no foot plates on the wheelchair. Staff pushed the wheelchair and the person's feet were dangling on the ground. Both instances had risks that people's feet would be injured. A staff member told us that wheelchairs were old and more foot rests were needed. The registered manager said this was not the case but this issue would be reviewed.

Staff members supplying medicines to people had a friendly approach when encouraging people to take their medicine. However, a staff member did not stay with the person until the medicine had been taken. The medicine was in a pot by the person whilst they were eating a meal. It was therefore available for anyone who took it. This did not protect people's safety.

These issues were was in breach of Regulation 12 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014, Safe Care and treatment. You can see what we have told the provider to do at the end of this report.

At times, staff understood the help that was needed to maintain safety and wellbeing and this was provided when they noticed people needed help. For example, staff told us that they checked that a person who wondered around the home was at risk of falling down in the lift so staff kept an eye on them. Staff said they checked equipment before it was used, such as whether the hoist was safe to use, the right size sling was used for people and that hoist batteries were working.

We saw evidence that equipment and appliances had been serviced such as the hoist, the lift and electrical appliances.

Some proper infection control procedures were observed. Staff wore aprons and gloves when they provided care. Evidence was in place that staff had received infection control training.

Staff records showed that before new members of staff were allowed to start, there was evidence in place that management took up some references with previous employers and with the Disclosure and Barring Service (DBS). DBS checks help employers to make safer recruitment decisions and ensure that staff employed were of good character.

A procedure was in place which indicated that when a safeguarding incident occurred, management staff were directed to take appropriate action. Referrals would be made to the local authority. This meant that other professionals outside the home were alerted if there were concerns about people's well-being, and the management did not deal with them on their own. The whistleblowing policy contained information about reporting any concerns to CQC and the local authority.

Staff told us they had never witnessed any abuse towards people living in the service. We spoke with staff about protecting people from abuse. Staff knew how to recognise the signs of possible abuse and their responsibility to report it to the management of the home, but some staff were uncertain how to report this to relevant external agencies if needed. The whistleblowing procedure included details of which agencies to contact but no contact details had been included. We received information after the inspection visit that included contact details.

People and their relatives considered the home to be a safe place due to staff being always around. They thought the service was secure. Staff were available to accompany people if they wished to go outside the building. One person said, "If anything was untoward there are always staff here. I have never seen any bullying by any staff on residents." Another person told us, "Safety here is excellent. They [staff] are very kind people."

The registered manager told us that sufficient staffing levels were in place to keep people safe. Staff said that staffing levels were sufficient to keep people safe and meet their needs. One person said, "I don't have to wait too long [for staff]." A relative said, "I think there is enough staff here." A staff member said, "We have enough staff here and get cover if we need it." We saw staff in communal areas to provide constant supervision of lounges where people sat to ensure people were safe.

People's personal evacuation plan had clear symbols on every person's room which showed the person's level of mobility in the case of evacuation. A master copy of the plan was kept by the fire panel to assist staff with evacuation.

People said that they received their medications on time. Medicine records showed that people received their medicine as prescribed. Medicines were securely locked with medicine keys held by the person in charge. Medicine trolleys were kept securely.

Medicines information included detailed information such as allergies so that people were not supplied with medicine they were allergic to. The treatment room and fridge temperatures had been checked to ensure medicines were kept at the right temperature to ensure their effectiveness.

People said that their human rights were respected. We saw that people had freedom of movement around the home and were encouraged to maintain contact with family and friends.

Requires Improvement

Is the service effective?

Our findings

Most people at Lavender Lodge spoke highly of staff and said that staff knew what they were doing. A person told us, "Yes, they are (trained). They are well able to look after me." A relative said, "The staff are well trained." Another relative said, "The caring here is better than other places. They [staff] know how to look after her [family member]."

People's care plans included assessments of their needs. People, except one person, told us that their needs were met and their choices were respected.

The registered manager ensured that the provider's policies concerning people's human rights were followed at the service. These included policies on equality and diversity. Staff were aware of people's ethnicity and cultural identity. They supported with those aspects of their lives by staff who were knowledgeable about their responsibilities and who understood people's rights.

Staff said that the training they had received had been largely effective in giving them the right skills and knowledge to enable them to support people appropriately. One member of staff said, "Some training has been good. Like the hoist training, which means I can move people properly and safely."

A staff member said that a number of staff that did not have English as a first language and did not receive support from management to improve their English. It is important to be able to communicate with people and some people got frustrated that they could not understand some staff due to their English not being clear. The registered manager said this support would be provided and this issue would be followed up.

Staff training information showed that staff had training in relevant issues such as infection control, health and safety, dementia and how to safeguard people from abuse. Staff had been not been provided with training on people's health conditions such as stroke, epilepsy and diabetes. The registered manager stated this would be reviewed to ensure staff had the proper knowledge to be able to effectively meet people's needs.

Staff had not undertaken Care Certificate induction training. This covers essential personal care issues and is nationally recognised as providing comprehensive training. To achieve the certificate care workers must successfully complete 15 training modules by demonstrating that that they have the right skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. We were later sent information that stated that care staff would receive this training shortly.

Staff told us that they started work, they shadowed a more experienced member of staff, so that they understood how to effectively meet people's needs. Staff told us they had supervision sessions to discuss their work and any issues they had. The supervision matrix showed that there was a plan to provide frequent supervision for staff for 2018. Supervision can be used for staff development and an exchange of information to drive change and improvements in the home.

People were happy with the food. One person said, "You get three choices. The food is very good." Another person said, "The food is excellent. I get a choice of two or three meals. I can help myself to tea and coffee."

We saw that drinks were available at all times and people were offered more drinks between drinks rounds. This helped to prevent dehydration. Information was displayed in the kitchen which set out the type of food people needed to effectively maintain their nutrition. There was also information about people's likes and dislikes,

We observed the midday meal which appeared a positive experience for people. Staff chatted to people. People who needed assistance were provided with this. People were asked if they wanted any more food and drinks. Staff were aware of people's nutritional needs.

People explained that when a doctor or optician was needed, this was always arranged for them. They told us their health needs were met. Staff ensured that people with specialist needs received their specialist check-ups with health professionals. A staff member said, "If we see someone looks ill then we get the nurse to have a look at them. If they are really ill then the nurse gets the GP."

We saw in people's records that their health needs were met. Each person had a clear list of all the health professionals. This contained detail about a variety of relevant health appointments people that people had attended. For example, there was evidence of people seeing their consultant and the optician. One person said, "I had a bad ear. The staff got the doctor to come and he gave me some steroid cream to clear it. He also gave me eye drops. The staff arrange appointments for me to see the mental health worker." A relative told us, "Her [person] glasses did not arrive from her old home. We discussed it with the manager who has asked for a doctor's visit about her eyes. He is coming tomorrow to arrange for her needs."

The registered manager stated people had support from the Dementia Rapid Response Team, audiology, Speech and Language Therapy and the consultant Psycho-geriatrician.

The premises were accessible to people. However, for people living with dementia who needed assistance to help them understand where they were, there were no pictures of people's choice installed on people's bedroom doors to give people direction as to where their bedrooms were. The menu was available to show people what food available for them to choose, although this was not prominently displayed. The registered manager said that these issues would be reviewed.

We saw that not all staff were aware of their responsibilities in relation to the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were being followed. The MCA is a law providing a system of assessment and decision making to protect people who do not have capacity to give consent themselves. The DoLS are a law that requires assessment and approval to ensure that any restrictions are in people's best interests, to keep them safe. The registered manager said staff would be reminded of mental capacity issues they needed to be aware of, as they had already received this training. We later received confirmation that more staff training was to be provided.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. There was evidence that people's mental capacity being assessed to ensure that people's capacity had been taken account of. Applications had been made to the relevant authority with regard to restricting people's choices in their own best interests. The registered manager said people were encouraged to independently do things for themselves even if they lacked capacity. For example, in one care plan this stated, "always consult [person's name] about planned intervention." This showed us that staff were aware that they needed to check with people as

to whether or not they wanted to receive care and support.

However, we saw information in a handover sheet, which stated that a person's behaviour did not improve, they would have to stay in their bedroom the rest of the day. This was against principles of the MCA and DoLS, of not restricting people's freedom of movement unless this is sanctioned by the authorising authority. This showed that the effective care was not always being provided to people in their best interests.

We asked staff about how they ensured people consented to the care when they provided care to people. They said that they talked with them, and asked for their consent before supplying personal care. We observed this, in the main, to be the case when staff provided care to people. However, a person told us that a GP had put him on diet without him knowing and that staff were enacting this against his wishes or knowledge. The registered manager said that this issue would be properly investigated.

Good

Is the service caring?

Our findings

All the people, except one, at Lavender Lodge told us they felt listened to and that staff were friendly and supportive and caring towards them. One person said, "I'm a newcomer here and feel respected." Another person told us, "The staff here are very polite, obliging and respectful to me." A relative said, "They (staff) speak kindly." Another relative said, "Relatives can visit. People can get a private space if they need it or go to their rooms"

People, except one person, and relatives told us that staff were polite, friendly, respectful and cared for them. They said staff talked with them unless they were very busy with other work. They said that staff knocked on doors before entering and maintained people's privacy.

When people showed signs of anxiety, when present, staff and management were quick to reassure them. They checked that people were feeling all right. Staff chatted to people and had a joke with them. People were called by their first names, which they appeared to enjoy.

Staff demonstrated that they knew the people who they were caring for, for example by being aware of people's food choices and what they wanted to wear. People said that family and friends were able to visit at any time and there were no restrictions. Relatives confirmed this.

People told us that staff encouraged their independence. For example, people were able to make themselves drinks. One person told us, "I am very independent. Staff let me shower in privacy and always knock on the door before coming in."

Staff were from a wide range of cultural and national origins. This was useful as a number of people living in the home were from these communities and had limited or no English and so some staff were able to communicate with people as they came from these communities.

People told us that there had been visits from the local church but they were able to opt out of joining in the service if they did not want to participate.

The literature of the service emphasised people's rights such as people's right to dignity and respect and that no one would receive less favourable treatment on ground such as race, gender, sexual orientation religion, or disability. This was not included in the staff handbook. The registered manager said this would be reviewed as it would help to promote people's rights to staff.

Everyone, except one person, told us that they exercised choice about important things in their lives. For example, what clothes they wanted to wear and what time they wanted to get up and go to bed. There were no set rules. We saw staff requesting a person come to the dining table. The person refused and staff respected that choice.

One person stated that a staff member, on seeing that they had a biscuit, had informed them that they

shouldn't be eating that, had told them to go to bed and had spoken to them in a dismissive manner. They had also said that staff member expected them to put their own shoes and socks on when they did not have capacity to do this. The registered manager said these issues would be investigated and followed up as needed.

Staff told us that people could choose their own lifestyle such as when to get up and when to go to bed. One staff member said that a person liked to get up late and have a late breakfast. We saw that was the case. People were able to walk around the premises as they liked. They could request food and drinks when they wanted and there were choices on the menu. They could help themselves to a snack when they wanted. These issues showed that staff respected people's choices of lifestyle.

People told us that staff tried to maintain peoples' independence as much as possible, for example by encouraging people to wash themselves where they could manage. Care plans supported this. This showed that people's independence had been promoted rather than staff intervening early and not allowing time for the person try to complete this task.

People from different cultural backgrounds felt their needs were respected and catered for. Staff told us that a person from a religious background did not eat certain foods. This had been respected. They had the opportunity to go to their place of worship but had chosen not to.

Staff were compassionate, kind and caring in our observations.

People told us that staff respected their privacy. Staff told us that they always knocked on people's doors and waited before entering. They closed blinds in bedrooms to maintain privacy and covered people.

These issues showed that staff, in the main, were caring, supportive and friendly to people and respected their rights.

People and their relatives said that they did not have an awareness of care plans as only one relative had knowledge of their family member's care plan. People's care plans did not show that they, or their relatives, were involved in decisions about how they wanted to live their lives. The registered manager said this would be followed up. We received information after the inspection this would be done.

Requires Improvement

Is the service responsive?

Our findings

All the people we spoke with, except one person, thought the personal care supplied by care staff was personal to them.

We found staff responded to people's needs. For example, a staff member noticed that a person was not eating their meal. They sat down and encouraged them to eat. Staff went to assist people when they called out. Staff continually asked people if they wanted drinks. A staff member noticed a person had food on their mouth and ask permission to wipe this for them. A person called out, asking for porridge. A staff member immediately responded and got this for them and assisted them with eating it.

Care plans contained valuable information to inform staff how to respond to people's needs. For example, making sure they had included of details about people and their preferred lifestyles. For example, about their personal histories, their likes and dislikes and what activities they liked. This gave staff information about how to support people and to help them to achieve what they wanted.

However, care plans were confusing with insufficient indexing. Risks assessments were kept separately from the care plan. It was difficult to ascertain the overall plan of care from these records, in particular the level of mobility, and what food and fluids were needed.

When we spoke with staff about people's needs, they were familiar with them as they were able to provide information about people as individuals. There was also information in care plans about meeting people's communication needs in terms of assisting people with getting regular sight checks.

The rota for people needing one-to-one care meant a change of staff approximately every two hours. This means they had a number of different staff. This affected their continuity of care, which could cause more confusion and difficulty maintaining a continuing relationship between staff and the person. The registered manager said this issue would be reviewed.

Care plans had been reviewed to ensure they still met people's needs. There was evidence that people and /their relatives had been involved in reviews of their care. There was a handover of information system from one staff shift to another. This ensured that staff could were informed how to respond to people's changing needs. This meant that relevant information was available to staff about how to provide personal care and support to people.

Staff told us that the registered manager asked them to read care plans. They said that information about people's changing needs had been communicated to them through handover of information between staff shifts, the 'daily bulletin'.

One person said, , "We have music once a week here by a musician with singing and dancing if people want. We also play bingo, dominoes and throwing stuff every day." Staff told us of other activities such as bingo, repeated from above playing music and dancing, doing people's nails and playing bowls.

However, we did not always see staff carrying out one-to-one care interacting with people. For example, there were long periods where staff sat with the person but did not interact with them. When a new staff member took over, there was good interaction about speaking to the person and asking them if they wanted to see pictures of birds, which the person was interested in. This meant there was inconsistency in responding to people's needs.

We only saw some activities provided during the day though in the morning there were none. A snakes and ladders game took place in the lounge of the older unit. in the afternoon, although most people in the lounge of the old unit sat quietly in their armchairs for most of the day. Music was played but this was pop music which did not appear to engage people as it was inappropriate to people's ages and backgrounds. After some time staff put on the TV. No one asked for this to be put on. A number of people whose English was not their first language, would not have understood the TV. In the new unit, the TV was on, but no one was watching it. Staff did not consult people as to whether they wanted music on instead. That meant people had not been involved in choosing what activities they wanted. The registered manager stated that the idea of employing an activities organiser, who knew how to provide appropriate activities for people living with dementia, would be considered.

The registered manager was aware of the new accessible information requirement. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The service could not provide information about ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Care plans did not include a section about people's communication needs and an assessment of whether they had any special needs. The registered manager said that work would be done to comprehensively carry this out.

A staff member showed us pictures of meals and a series of pictures on A4 paper that staff used to understand what non English speakers wanted, if they were happy or not and to indicate whether they agreed or not with intended staff actions. This provided a method to provide some sort of effective communication with people.

One person told us, "I have no complaints or concerns. If I did I would go to the nurse in charge or the manager." A relative said, "The manager has an open door policy if you are worried about anything."

A relative told us that the care plan agreed that personal care was to be provided by male staff. However, this had been carried out by a female staff member on one occasion. This had been discussed with the registered manager who had taken action to ensure that this would not happen again.

People and some relatives told us they were not aware of how to make a complaint as they had not seen the complaints procedure. The registered manager said this would be followed up.

We asked to look at complaints records that had been received for the previous 12 months. We were not provided with these records, so we have asked for them subsequently to see whether complaints had been properly investigated with proper action taken if any issues were identified.

The complaints procedure implied that CQC would investigate complaints. CQC do not have the legal powers to investigate or respond to specific complaints about care providers. The registered manager said

this procedure would be amended.

Requires Improvement

Is the service well-led?

Our findings

The home was not comprehensively well led.

The previous inspection found a breach of regulation 12, safe care and treatment. The rating awarded had been requires improvement. We found at this inspection visit there was a lack of improvements.

The home had a registered manager, which is a condition of registration. However, there was no information was available which clarified governance duties and responsibility for management and staff. This did not ensure that people and relatives knew all relatives the responsibilities of management and staff.

People and relatives were not systematically consulted about the quality of care, and whether they had any worries or any suggestions on how to improve the home. Meetings with people living in the service and relatives had not taken place. This showed that there were no recognised mechanisms for people or their relatives to influence the running of the home.

There was no system in place to ensure quality was monitored and assessed within the service, as there were no audits on important issues such as medicine audits, staff training, staff recruitment and health and safety issues. Issues we identified on this inspection had not been identified by the manager of staff and followed up. For example, insufficient risk assessments to keep people safe and, some staff practice not keeping people safe, lessons not always been learned from past safety incidents, medicine not always being safely provided to people and people not being comprehensively protected from the risk of injury or the risk from infection.

An infection control audit had been carried out which identified action needed but there was no information on how and when this was to be carried out. People, their relatives, staff and professionals had not been supplied with questionnaires to comment on the quality of the services.

We found that the registered manager had not thoroughly understood the legal obligations including the conditions of their registration. A comprehensive system was not in place for notifying the Care Quality Commission of serious incidents involving people using the service.

These issues were in breach of Regulation 17 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014, Good Governance. You can see what we have told the provider to do at the end of this report.

People knew who the registered manager was. They were observed in both units of the home throughout the day. They were considered approachable by everyone spoken with. People, except one person, thought the home was well managed. One person said, "I have seen the manager wander around and talk with people. She checks it is as it should be. She is out and about and takes care of staff." A relative said, "The atmosphere here is good. I am welcomed here."

Most people and relatives felt the home was a happy place for them and that the atmosphere was a good one. A person said "The atmosphere here is good. I am welcome here."

Another person told us, "I know the manager ..she says hello to me." Another person said that the registered manager had an open door policy so that people could discuss any concerns, "She is very approachable."

Most people and some relatives said they would recommend the home to others. One person said, "I think it is a happy place." Another person told us, "The atmosphere here is positive."

A person said, "The home manager checks out with me personally if everything is alright. I have heard other residents being asked also." However, this was not always the case. One person told us, "No one checks on what I think of the service."

Staff told us that they receive good support from management staff. A staff member said, "The manager is very supportive. I needed time off work due to a personal issue and I got it without any question."

This was supported by the large number of positive interactions we saw between staff, and management and people who lived in the home.

Staff told us that the registered manager was always available to speak with them at any time to help them. One staff member said, "If I need to go to the office and ask anything, I will. They always listen to me." Another staff member said that in the past some staff attitudes were negative within some of the staff team. They had gone to management and spoke about this. They said that action had been taken as these attitudes had improved considerably.

Staff said there had been staff meetings where issues were discussed including fire precautions. Staff meeting minutes contained relevant issues such as reminding staff about infection control, changes in people's care and health and safety procedures.

This showed us that staff had a voice in organising the home to the benefit of people living there.

During the visit we observed that staff members were knowledgeable about the people that who used the service. They said that management expected them to make sure that people were treated properly, with respect, ensuring their welfare and giving them choices. They said they would recommend the home to relatives and friends.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service had not comprehensively kept people safe. Risk assessments to promote people's safety were not properly calculated or detailed enough, some staff practice did not keep people safe, and medicine was not always safely provided to people. Lessons had not always been learned from past safety incidents. Medicine had not always been safely supplied to people. People had not been comprehensively protected from the risk of injury or the risk from infection.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Essential systems had not been audited in order to ensure that people were always provided with a quality service. We had not always been informed, as legally required, of serious incidents affecting the service. No information was available which clarified governance duties and responsibilities for management and staff. People or their relatives had not been comprehensively consulted on the running of the service.

The enforcement action we took:

A warning notice was issued to the provider to ensure that essential services were audited to produce a quality service for people living in the home.